GET PHYSICAL
PAULA BLAKER, PHYSICAL THERAPIST

NEW PATIENT/CLIENT QUESTIONNAIRE

Last name _____ First _____ Middle Initial ____ Date _____
Age _____ Date of Birth _____ Height _____ Weight _____
Nickname _____ Gender _____ Pronoun Preferred _____
Address _____
Cell Phone _____ Home Phone _____

Occupation _____ Currently Working? If yes, how many hours per week? _____

How did you learn about GET PHYSICAL LLC? _____

Do you give me permission to share findings and converse with your primary doctor? _____

Primary Care Physician _____ Phone #_____

Name of spouse, partner, parent, relative, or friend _____ Phone # _____

When was the last time you experienced optimal health? _____

How would you describe your current overall health condition? Excellent Good Fair Poor

How motivated are you to make changes to your health? Very Somewhat Not Very

What health concern would you like to discuss in your initial visit? _____

_____

Do you have other health concerns you would like to address at subsequent visits? List in order of importance.

1. _____ 3. _____
2. _____ 4. _____

What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms? Please indicate for each concern.

_____

_____

Have you received therapy for this condition? If yes, what kind and when? _____

Has your condition been getting: Better Worse Staying the Same

Are your symptoms: Constant Intermittent

What makes your condition better? (please check all that apply)

__Bending __Movement __Rest __Heat __Ice __Sitting __Standing
__Rising __Walking __Stairs __Lying __Medication __Changing Position
__Better in a.m. __Better as day progresses __Better in p.m.

What makes your condition worse? (please check all that apply)

__Bending __Movement __Rest __Heat __Ice __Sitting __Standing
__Rising __Walking __Stairs __Lying __Medication __Changing Position
__Worse in a.m. __Worse as day progresses __Worse in p.m.

Medical/Surgical History (Please check any conditions you have or have ever had)

__Arthritis __Multiple Sclerosis __Head injury __Spinal Cord Injury
__Muscular Dystrophy __Osteoporosis __Parkinson's Disease __Diabetes
__Seizures/Epilepsy __Blood Disorders __Thyroid Problems __Ulcers/Stomach Problems
__Kidney problems __Infectious Disease __Repeated infections __Lung Problems
__Heart Problems __Pacemaker __Stroke __Any metal implants
__Depression __Skin Diseases __Circulation/vascular problems
__Cancer (Where?_____ Treatment?_____)
__Broken bones/fractures (Where: _____ When?_____ Require surgery?_____)

Within the past year, have you had any of the following symptoms?

__Chest pain __Difficulty sleeping __Difficulty walking __Heart palpitations __Loss of appetite
__Headaches __Cough __Nausea/vomiting __Urinary Problems __Bowel Problems
__Joint pain or swelling? Where?_____ __Shortness of Breath __Difficulty swallowing __Weight loss/gain
__Hearing problems __Vision problems __Dizziness or blackouts __Coordination problems __Weakness
__Pain at night __Fever/chills/sweats __Loss of balance __Falls When? _____

Current Medications _____

Do you participate in any sports, exercise programs, or activities on a regular basis? YES NO

If YES, you participate in: _____

Because of your concerns or issues, what specific activities are you have difficulty performing?

_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you smoke or have a history of smoking? YES NO

If YES, how many packs per day or date you became a non-smoker _____

How many ounces of water do you consume per day? _____

Do you have house pets? YES NO [Note: House pets can pose significant fall risks.]

If YES, what type of pet? _____ If pet is a dog, who is primary dog walker? _____

What are your goals/outcomes you hope to achieve with physical therapy or wellness services?

1. _____
2. _____
3. _____

Signature: _____ **Name:** _____ **Date:** _____